

# FY06 HEALTH PLAN DESCRIPTION FORM – INO

	INO - 30	INO - 40
	In-Network Only	In-Network Only
<b>Important Note:</b> This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.		
<b>Part A: Type of Coverage</b>		
1. Type of Plan	Preferred Provider Organization	
2. Out-of-Network Care Covered? <sup>1</sup>	No, except for life or limb threatening illness or injury	
3. Areas of Colorado where Plan is Available	Plan is available throughout Colorado	
<b>Part B: Summary of Benefits</b>		
4. Annual Deductible		
a) Individual	N/A	N/A
b) Family		
5. Out-of-Pocket maximum per plan year <sup>2</sup>		
a) Individual	\$1000 plus copays	\$2000 plus copays
b) Family	\$3000 plus copays	\$6000 plus copays
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	Not applicable	
7A.Covered Providers	Great-West Healthcare Preferred Provider Network; Pharmacy Services provided by Express Scripts by arrangement with Great-West Healthcare	
7B.With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. Routine Medical Office Visits	\$30 PCP copay \$50 Specialist copay	\$40 PCP copay \$65 Specialist copay
9. Preventive		
a) Children's services	\$30 copay	\$40 copay
b) Adults' services	\$30 copay	\$40 copay
10. Maternity		
a) Prenatal care	\$30 copay/visit	\$40 copay/visit
b) Delivery & Inpatient well baby care	\$250/day up to 3 days/admission	90%
11. Prescription Drugs Level of coverage and restrictions on prescriptions		
a) Retail		
- Generic	\$10	\$10
- Brand Name	\$25	\$25
- Non-formulary	\$50	\$50
	after \$100 per person Rx deductible (30 day supply) (Rx deductible applies to in/out network and retail/mail order.)	after \$100 per person Rx deductible (30 day supply) (Rx deductible applies to in/out network and retail/mail order.)
b) Mail Order		
- Generic	\$20	\$20
- Brand Name	\$50	\$50
- Non-formulary	\$100	\$100
	after \$100 per person Rx deductible (90 day supply) (Rx deductible applies to in/out network and retail/mail order.)	after \$100 per person Rx deductible (90 day supply) (Rx deductible applies to in/out network and retail/mail order.)
c) Self-admin. injectibles disp. thru pharmacy	Member pays 30%, not to exceed \$250 per 34 day supply or \$500 per 90 day supply	Member pays 30%, not to exceed \$250 per 34 day supply or \$500 per 90 day supply

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d) <b>Injectibles admin. in office or OP facility</b>	Member pays 30%	Member pays 30%
<b>12. Inpatient Hospital</b>	\$250/day co-pay, up to 3 days per admission ( <b>DOES NOT</b> apply to out-of-pocket max.)	Member pays 10%
<b>13. Outpatient/Ambulatory Surgery</b>	\$150 copay per surgery or invasive diagnostic tests	\$200 copay per surgery or invasive diagnostic tests plus 20%
<b>14.</b>		
a) <b>Laboratory</b>	20% if not part of office visit	20% if not part of office visit
b) <b>X-ray</b>	20% if not part of office visit	20% if not part of office visit
c) <b>MRI/PET/CAT scans</b>	\$75 copay plus 20%	\$100 copay plus 20%
<b>15. Emergency Care<sup>3</sup></b>	\$100 copay waived if admitted	\$150 copay plus 20%, waived if admitted
<b>16. Ambulance</b>		
a) <b>Ground</b>	\$200 copay per trip, maximum benefit \$350	\$200 copay per trip, maximum benefit \$350
b) <b>Air</b>	\$500 copay per trip, maximum benefit \$2,500	\$500 copay per trip, maximum benefit \$2,500
<b>17. Urgent Care</b>		
a) <b>Inpatient</b>	Same as inpatient hospital.	Same as inpatient hospital.
b) <b>Outpatient</b>	\$50 copay	\$75 copay
<b>18. Biologically Based Mental Illness<sup>4</sup> Care</b>	Same as medical care.	Same as medical care.
<b>19. Other Mental Health Care</b>		
a) <b>Inpatient care</b>	50%, 45 full/90 partial days per year , combined with Alcohol & Substance Abuse	50%, 45 full/90 partial days per year, combined with Alcohol & Substance Abuse
b) <b>Outpatient care</b>	50%, 30 visits / yr , combined with Alcohol & Substance Abuse	50%, 30 visits / yr, combined with Alcohol & Substance Abuse
<b>20. Alcohol &amp; Substance Abuse</b>		
a) <b>Inpatient Rehab</b>	50%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health	50%, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health
b) <b>Outpatient</b>	50%, 30 visits per year, combined with other mental health, 60 visits lifetime	50%, 30 visits per year, combined with other mental health, 60 visits lifetime
<b>21. Physical, Occupational &amp; Speech Therapy</b>		
a) <b>Inpatient</b>	Included in hospital	Included in hospital
b) <b>Outpatient</b>	\$30 copay, 20 visits / year for each therapy	\$40 copay, 20 visits / year, for each therapy
<b>22. Durable Medical Equipment</b>		
a) <b>Inpatient</b>	Included in hospital	Included in hospital
b) <b>Outpatient including supp.</b>	20%, \$3,000/year, combined with oxygen (prosthetic devices are not subject to \$3000 max, but expenses for such devices are applied to, and reduce, the \$3000 max.)	20%, \$3,000/year, combined with oxygen (prosthetic devices are not subject to \$3000 max, but expenses for such devices are applied to, and reduce, the \$3000 max.)
<b>23. Oxygen</b>		
a) <b>Inpatient</b>	Included in hospital	Included in hospital
b) <b>Outpatient</b>	20%, \$3,000/year, combined with DME	20%, \$3,000/year, combined with DME
<b>24. Organ Transplants</b>	100%	90%
<b>25. Home Health Care</b>	\$30 copay, 60 visits / year	\$40 copay/ 60 visits / year
<b>26. Hospice</b>		
a) <b>Inpatient</b>	20%, 30 days / year	20%, 30 days / year
b) <b>Outpatient</b>	20%, 91 days / year	20%, 91 days / year
<b>27. Skilled Nursing Facility Care</b>	Not covered	Not covered
<b>28. Dental Care</b>	Not covered	Not covered

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29. Vision Care	\$30 copay, one exam every 12 months. Discounted lenses/hardware	\$40 copay, one exam every 12 months. Discounted lenses/hardware
30. Chiropractic Care	\$30 copay, maximum benefit \$750/ year	\$40 copay, maximum benefit \$750/ year
31. Significant Additional Covered Services	Hearing aid: limited to \$500 every 3-years Infertility: 80% max. ben. \$2,500/year	Hearing aid: limited to \$500 every 3-years Infertility: 80% max. ben. \$2,500/year
<b>Part C: Limitations and Exclusions</b>		
32. Period During which Pre-Existing Conditions are not Covered <sup>5</sup>	Not applicable. Plan does not impose limitation periods for pre-existing conditions	Not applicable. Plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No
34. How Does the Policy Define a "Pre-existing Condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. What Treatments & Conditions are Excluded Under this Policy?	See summary plan description for list of exclusions.	See summary plan description for list of exclusions.
<b>Part D: Using the Plan</b>		
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Not if the provider participates with Great-West Healthcare	Not if the provider participates with Great-West Healthcare
39. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)	1-888-ST8-OFCO (1-888-788-6326)
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>6</sup>	Great-West Healthcare P.O. Box 22222 Fort Scott, KS 66701 (1-800-663-8081)	Great-West Healthcare P.O. Box 22222 Fort Scott, KS 66701 (1-800-663-8081)
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Number 179528 Self-funded large group.	Policy Number 179528 Self-funded large group.
43. Does the plan have a binding arbitration clause?	No	No
<b>Part E: Cost</b>		
44. What is the cost of this plan? a) Employee Only b) Employee + Child(ren) c) Employee + Spouse d) Family	Final rates will be made available via the Benefits newsletter, <i>HealthLine</i> , and on the Benefits website <a href="http://www.colorado.gov/dpa/dhr/benefits">www.colorado.gov/dpa/dhr/benefits</a> .	

**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT**

<sup>1</sup>“Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).

<sup>2</sup>Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copay, depending on the contract for that plan.

<sup>3</sup>“Emergency care” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

<sup>4</sup>“Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>5</sup>Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

<sup>6</sup>Grievances. The formal grievance process (not to be confused with appeals) is in development.